



**Omega Medical Center**  
Your Occupational Health Resource

*fax:* (302) 454-7733  
15 Omega Drive • Building K  
Newark, Delaware 19713  
(302) 368-5100

**CLIENT PROFILE**

COMPANY INFORMATION

Date \_\_\_\_\_

Company Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
General Phone # \_\_\_\_\_ Fax # \_\_\_\_\_  
Number of Employees \_\_\_\_\_ Number of Shifts \_\_\_\_\_  
Principal Business Description \_\_\_\_\_  
\_\_\_\_\_

Potential Hazards, Exposures (e.g. toxins, noise, etc...) Please Attach MSDS  
\_\_\_\_\_  
\_\_\_\_\_

Name of Company Doctor and/or Medical Person on Site \_\_\_\_\_  
Medical Department # \_\_\_\_\_

BILLING INFORMATION

Worker's Compensation Insurance: Self \_\_\_\_\_ Co. \_\_\_\_\_  
Verification to Bill Worker's Compensation Insurance Direct: Yes \_\_\_\_\_ No: \_\_\_\_\_  
Worker's Compensation Billing Name and Address: \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Attention: \_\_\_\_\_ Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

**PLEASE LIST THE FOLLOWING COMPANY PERSONNEL RESPONSIBLE FOR:**

Primary Contact	Title	Phone
_____	_____	_____

Secondary Company Contact \_\_\_\_\_

Safety \_\_\_\_\_

Injury Reporting 1. \_\_\_\_\_  
2. \_\_\_\_\_

Drug Screen Reports 1. \_\_\_\_\_  
2. \_\_\_\_\_

Filing Worker's Compensation \_\_\_\_\_

Company Billing \_\_\_\_\_

Physical Exam Reports \_\_\_\_\_

Scheduling Physical \_\_\_\_\_

**IMPORTANT:** Please Notify **Omega Medical Center** of any changes in above personnel.

**INSTRUCTIONS FOR INJURY MANAGEMENT**

Light Duty Available  Yes  No If yes, explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Special Requests for Referrals/Physicians, etc \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS FOR PHYSICAL EXAMINATION MANAGEMENT**

Pre-Placement \_\_\_\_\_

Annual \_\_\_\_\_

Periodic for Occupational Disease Exposures \_\_\_\_\_

Executive \_\_\_\_\_

Return-to-Work \_\_\_\_\_

Exit \_\_\_\_\_

Other \_\_\_\_\_

**DRUG AND ALCOHOL SCREENING**

N.I.D.A. Drug Screen \_\_\_\_\_

DuPont Drug Screen \_\_\_\_\_

Regular Drug Screen \_\_\_\_\_

(all chain of custody)

Drug Screen Collections (only) \_\_\_\_\_

Blood Alcohol \_\_\_\_\_

**EMPLOYER'S AUTHORIZATION FOR TREATMENT**

Omega Medical Center is hereby authorized and directed to treat employees sent to Omega Medical Center from the employer. Reasonable medical care is hereby authorized to address symptoms and complaints presented to Omega from the patient and the employer hereby acknowledges its responsibility for any and all medical charges generated through treatment by Omega.

Authorized Employer's Signature \_\_\_\_\_